Employment Development Department
State of California

Claim for Disability Insurance Benefits – Claim Statement of Employee

Type or print in BLOCK CAPITAL LETTERS with BLACK INK.

1. YOUR SOCIAL SECURITY NUMBER **2. IF YOU HAVE EVER USED OTHER SOCIAL SECURITY NUMBERS, SHOW THOSE NUMBERS BELOW**

3. DATE YOUR DISABILITY BEGAN (M M D D Y Y) **4. LAST DATE YOU WORKED** (M M D D Y Y) **5. HAVE YOU WORKED ANY FULL OR PARTIAL DAYS SINCE YOUR DISABILITY BEGAN?** ☐ YES ☐ NO **6. DATE YOU RECOVERED OR RETURNED TO WORK (IF ANY)** (M M D D Y Y)

7. GENDER ☐ MALE ☐ FEMALE **8. YOUR LEGAL NAME** (FIRST NAME, MIDDLE NAME OR INITIAL, LAST NAME) **9. YOUR DATE OF BIRTH** (M M D D Y Y)

10. OTHER NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

11. LANGUAGE YOU PREFER TO USE ☐ ENGLISH ☐ ESPAÑOL ☐ OTHER

12. YOUR MAILING ADDRESS (IF YOU WISH TO RECEIVE MAIL AT A PRIVATE MAIL BOX—NOT A US POSTAL SERVICE BOX—YOU MUST SHOW THE NUMBER IN THE "PMB#" SPACE.)

↑NUMBER / STREET / P.O. BOX / APARTMENT OR SPACE #↑ ↑PMB # (PRIVATE MAIL BOX #)↑

↑CITY ↑STATE ↑COUNTRY (IF NOT UNITED STATES OF AMERICA) ↑ZIP CODE

13. YOUR AREA CODE AND TELEPHONE NUMBER **14. YOUR RESIDENCE ADDRESS, IF DIFFERENT FROM YOUR MAILING ADDRESS**

↑NUMBER / STREET / APARTMENT OR SPACE #

↑CITY ↑STATE ↑COUNTRY (IF NOT UNITED STATES OF AMERICA) ↑ZIP CODE

15. WHY DID YOU STOP WORKING?

16. YOUR LAST OR CURRENT EMPLOYER – IF YOUR LAST OR CURRENT EMPLOYMENT WAS SELF-EMPLOYMENT, ENTER "SELF"

↑EMPLOYER 'S AREA CODE AND TELEPHONE NUMBER ↑NAME OF EMPLOYER

↑NUMBER / STREET / SUITE #

↑CITY ↑STATE ↑COUNTRY (IF NOT UNITED STATES OF AMERICA) ↑ZIP CODE

17. YOUR REGULAR OCCUPATION

18. IF YOUR EMPLOYER CONTINUED TO PAY YOU, INDICATE TYPE OF PAY ☐ SICK ☐ VACATION ☐ OTHER

19. MAY WE DISCLOSE BENEFIT PAYMENT INFORMATION TO YOUR EMPLOYER? ☐ YES ☐ NO

20. SECOND EMPLOYER (IF YOU HAVE MORE THAN ONE EMPLOYER)

↑EMPLOYER 'S AREA CODE AND TELEPHONE NUMBER ↑NAME OF EMPLOYER

↑NUMBER / STREET / SUITE #

↑CITY ↑STATE ↑COUNTRY (IF NOT UNITED STATES OF AMERICA) ↑ZIP CODE

21. AT ANY TIME DURING YOUR DISABILITY WERE YOU IN THE CUSTODY OF LAW ENFORCEMENT AUTHORITIES BECAUSE YOU WERE CONVICTED OF VIOLATING A LAW OR ORDINANCE? ..... YES NO

Claim Statement of Employee - continued

22. PLEASE RE-ENTER YOUR SOCIAL SECURITY NUMBER .....

23. IF YOU ARE A RESIDENT OF AN ALCOHOLIC RECOVERY HOME OR A DRUG-FREE RESIDENTIAL FACILITY, SHOW THE NAME, TELEPHONE NUMBER, AND ADDRESS

↑NAME OF FACILITY ↑AREA CODE AND TELEPHONE NUMBER

↑ADDRESS OF FACILITY (NUMBER AND STREET / CITY / STATE / ZIP CODE)

24. WAS THIS DISABILITY CAUSED BY YOUR JOB? YES NO

25. HAVE YOU FILED OR DO YOU INTEND TO FILE FOR WORKERS' COMPENSATION BENEFITS? YES — IF YES, COMPLETE 26 THROUGH 30; NO — IF NO, SKIP TO DECLARATION AND SIGNATURE

26. DATE(S) OF INJURY SHOWN ON YOUR WORKERS' COMPENSATION CLAIM M M D D Y Y M M D D Y Y MORE

27. WORKERS' COMPENSATION INSURANCE COMPANY

↑COMPANY NAME ↑AREA CODE AND TELEPHONE NUMBER

↑NUMBER / STREET / SUITE #

↑CITY ↑STATE ↑ZIP CODE

28. WORKERS' COMPENSATION ADJUSTER

↑ADJUSTER NAME ↑AREA CODE AND TELEPHONE NUMBER

29. EMPLOYER SHOWN ON YOUR WORKERS' COMPENSATION CLAIM

EMPLOYER'S NAME AREA CODE AND TELEPHONE NUMBER

30. YOUR ATTORNEY (IF ANY) FOR YOUR WORKERS' COMPENSATION CASE

↑ATTORNEY'S NAME ↑AREA CODE AND TELEPHONE NUMBER

↑NUMBER / STREET / SUITE #

↑CITY ↑STATE ↑ZIP CODE

Declaration and Signature.

- By my signature on this claim statement, I claim benefits and certify that for the period covered by this claim I was unemployed and disabled.
- I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both.
- I declare under penalty of perjury that the foregoing statement, including any accompanying statements, is to the best of my knowledge and belief true, correct, and complete.
- By my signature on this claim statement, I authorize my attending physician, practitioner, hospital, vocational rehabilitation counselor, employer, and the California Department of Industrial Relations to furnish and disclose to State Disability Insurance all facts concerning my disability and wages or earnings that are within their knowledge and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability that are under their control.
- By my signature on this claim statement, I authorize release and use of information as stated in the "Information Collection and Access" portion of this form.
- I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of ten years from the date of my signature or the effective date of the claim, whichever is later.

Claimant's Signature (DO NOT PRINT)	Date Signed

If your signature is made by mark (X), it must be attested by two witnesses with their addresses

1st Witness Signature and Address	2nd Witness Signature and Address

Employment Development Department
State of California

Claim for Disability Insurance Benefits – Doctor's Certificate

Type or print in BLOCK CAPITAL LETTERS with BLACK INK.

31. PATIENT'S FILE NUMBER | **32. PATIENT'S SOCIAL SECURITY NO.** | **33. PATIENT'S LAST NAME**

34. DOCTOR'S NAME AS SHOWN ON LICENSE | **35. DOCTOR'S TELEPHONE NUMBER** | **36. DOCTOR'S STATE LICENSE**

37. DOCTOR'S ADDRESS – NUMBER AND STREET, CITY, STATE, COUNTRY (IF NOT USA), ZIP CODE

38. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM

FROM (M M D D Y Y) TO (M M D D Y Y) AT INTERVALS OF: DAILY | WEEKLY | MONTHLY | AS NEEDED

39. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?

NO – IF NO, SKIP TO THE DOCTOR'S CERTIFICATION SECTION

YES – IF YES, ENTER DATE DISABILITY BEGAN: (M M D D Y Y)

40. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR/CUSTOMARY WORK ("UNKNOWN," "INDEFINITE," ETC., NOT ACCEPTED) (M M D D Y Y)

41. ICD9 DISEASE CODE(S), PRIMARY (REQUIRED UNLESS DIAGNOSIS NOT YET OBTAINED) | **42. ICD9 DISEASE CODE(S), SECONDARY**

43. DIAGNOSIS (REQUIRED) – IF NO DIAGNOSIS HAS BEEN DETERMINED, ENTER OBJECTIVE FINDINGS OR A DETAILED STATEMENT OF SYMPTOMS

44. FINDINGS – STATE NATURE, SEVERITY, AND EXTENT OF THE INCAPACITATING DISEASE OR INJURY. INCLUDE ANY OTHER DISABLING CONDITIONS.

45. TYPE OF TREATMENT / MEDICATION RENDERED TO PATIENT

46. IF PATIENT WAS HOSPITALIZED, PROVIDE DATES OF ENTRY AND DISCHARGE (M M D D Y Y) TO (M M D D Y Y)

47. DATE AND TYPE OF SURGERY / PROCEDURE PERFORMED OR TO BE PERFORMED (M M D D Y Y) (TYPE OF SURGERY OR PROCEDURE) | **ICD 9 PROCEDURE CODE(S)**

48. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, WHAT DATE DID PREGNANCY TERMINATE OR WHAT DATE DO YOU EXPECT DELIVERY? (M M D D Y Y)

49. IF PREGNANCY IS / WAS ABNORMAL, STATE THE ABNORMAL AND INVOLUNTARY COMPLICATION CAUSING MATERNAL DISABILITY

50. BASED ON YOUR EXAMINATION OF PATIENT, IS THIS DISABILITY THE RESULT OF "OCCUPATION," EITHER AS AN "INDUSTRIAL ACCIDENT" OR AS AN "OCCUPATIONAL DISEASE"? (INCLUDE SITUATIONS WHERE PATIENT'S OCCUPATION HAS AGGRAVATED PRE-EXISTING CONDITIONS.) YES | NO

51. ARE YOU COMPLETING THIS FORM FOR THE SOLE PURPOSE OF REFERRAL / RECOMMENDATION TO AN ALCOHOLIC RECOVERY HOME OR DRUG-FREE RESIDENTIAL FACILITY AS INDICATED BY THE PATIENT IN QUESTION 23? YES | NO

52. WOULD DISCLOSURE OF THIS INFORMATION TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? YES | NO

Doctor's Certification and Signature (REQUIRED): Having considered the patient's regular or customary work, I certify under penalty of perjury that, based on my examination, this Doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.

I further certify that I am a _____ (TYPE OF DOCTOR) _____ (SPECIALTY, IF ANY) licensed to practice in the State of _____

▶ _____
ORIGINAL SIGNATURE OF ATTENDING DOCTOR – RUBBER STAMP IS NOT ACCEPTABLE

▶ _____
DATE SIGNED

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Section 1143 requires additional administrative penalties.